MILLENNIUM HEALTHCARE	AUTHORIZATION TO ACCESS, DISCLOSE OR RELEASE ePHI		Medical Record #:
Patient Name:	**Date:**	**DOB:**	☐ **Male** ☐ **Female**

I hereby authorize Millennium Physician Group, LLC to release my Protected Health Information as described below.

Who: Name and address of person, provider, or organization receiving the information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email address: _____

Date(s) of Service: _____

What: Place a check for the description of information to be released:

□ Office visits
□ Medication history
□ Lab reports
□ X-ray / MRI / CT reports
□ X-ray / MRI / CT films
□ Mammography films
□ History & Physical / Discharge Summary
□ Progress Notes
□ Entire medical record
□ Other (please be specific)
_____
_____

Sensitive Information: Please read carefully. Place a check in front of the information you want released.

□ HIV/AIDS test/treatment
□ Sexually transmitted disease
□ Drug/alcohol problem
□ Mental health information
□ Genetic testing
□ Sexual assault
□ Abortion
□ DNA samples or analyses

Parent of Minor Child: Parental consent for information below must be given prior to release of this information. Place a check in front of the minor child's information you want released.

□ Biometric scan of minor child
□ Record of minor child's blood or deoxyribonucleic acid (DNA)

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Why: Place a check for the specific purpose of the release.
□ Continuity of care (to another provider)
□ Personal use
□ Legal
□ Other (please be specific) _____

Place initials before statements below if you understand:

_____ **I understand** that this authorization is voluntary. If I do not sign this form, my healthcare from Millennium Physician Group, LLC and the payment for this healthcare will not be affected.

_____ **I understand** that once my information is released, it may no longer be protected by federal privacy regulations.

_____ **I understand** that I may see and copy the information described on this form if I ask for it, and I will get a copy of this form after I sign it.

_____ **I understand** if an organization is seeking this authorization a copy must be provided to the individual signing the authorization.

_____ **I understand** that this authorization will expire (specify date or event) _____.

_____ **I understand** that after I have signed this form, I may change my mind and cancel (revoke) this authorization at any time by notifying Millennium Physician Group, LLC, Privacy Officer in writing. But if I do, it will not have any effect on actions Millennium Physician Group, LLC took before the revocation was received.

_____ **I understand** that copies made and sent on my behalf directly to another Physician are free of charge.

Copies that are made and delivered to me will be billed as follows:
Paper records: The first 10 pages at no charge; the next 25 pages at $1.00 per page; the remaining pages at $.25 per page.
Medical CDs: $7.00 per CD.

□ For medical records delivered to me I request paper.
□ For medical records delivered to me I request CD.

_____ _____
Signature of patient or patient's representative Date

Printed name if patient's representative: _____

Relationship to patient: _____